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Priority Public Health Conditions: Task Group 8

Summary and proposals

The full report of the task group can be found at

http://www.ucl.ac.uk/gheg/marmotreview/consultation/Priority_public_health_conditions_report

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1. Overall Aim of the Marmot Review:

To propose an evidence-based strategy for reducing the health inequalities in England from 2010, including policies and interventions that address the social determinants of health inequalities.

2. Contribution of Task Group 8:

Task Group 8's work focuses on inequalities in a limited number of key 'public health conditions': the big causes of premature death (cardiovascular disease and cancer); obesity; and other big public health burdens such as risk-taking behaviours in younger adults (alcohol, drugs, violence), mental ill-health throughout life, and the threats to wellbeing in older people. Task Group 8 reviewed new and emerging evidence on the effects of particular policies, strategies, structures and interventions on reducing inequalities in these conditions, with a particular focus on the social determinants. On the basis of the evidence we have collated and interpreted, we have made a total of 15 proposals on what we consider to be plausible policy directions and changes in practice. We have subdivided our proposals into five key proposals, one research proposal and nine supporting proposals. Proposals in the latter category are those which overlap with the proposals of the other eight Marmot review task groups (cross-referenced where appropriate). The summary of evidence included in this Summary is by nature brief, and the full evidence review and details of the references quoted are contained in the main Report of the Task Group.

3. Inequalities in Priority Public Health Conditions

3.1. Cardiovascular Disease and Cancer

Cardiovascular diseases (CVD) are the main cause of death in the United Kingdom, accounting for over 200,000 deaths every year, followed by cancers which account for over 154,000 deaths (Cancer Research UK, 2006). Within

these numbers there are serious inequalities between geographical areas, gender, socioeconomic group, and ethnicity. Chronic conditions disproportionately afflict the poor and the marginalized and create further hardship and deepen poverty. Mortality and morbidity from cardiovascular disease and cancer are unevenly distributed across society with a disproportionate burden in low-income groups, minority ethnic groups and people living in the north of England. Mortality and morbidity from cardiovascular disease and cancer are also higher amongst people with poor mental health (after controlling for socioeconomic variables) suggesting an interaction between mental and physical well-being. Recent data from the British Heart Foundation indicate that there are 2.7 times more CVD deaths among men in the most deprived twentieth compared with the least deprived twentieth of the population (Scarborough et al., 2008). Similarly, socioeconomic status was shown to be related to lung cancer incidence, with people with low levels of education having a higher incidence of cancer (Menvielle et al., 2009). Likewise, modifiable risk factors for CVD and cancers such as smoking, physical inactivity, excess alcohol consumption or obesity are elevated in these population groups (Scarborough et al., 2008). As in other high-income countries, while reductions in the prevalence of some risk factors have been decreasing, inequalities have instead been widening (Clarke and Hayes, 2009). Cigarette smoking is one such example.

3.2. Obesity

Obesity is causally linked to such chronic diseases as diabetes, coronary heart disease, stroke, hypertension, osteoarthritis and certain forms of cancer (Cross-Government Obesity Unit, 2008). It is predicted that as the population grows, and ages, the burden of diseases associated with obesity will result in escalating numbers of early deaths and long-term incapacity with associated reductions in quality of life (Cross-Government Obesity Unit, 2008).

Childhood obesity is a particular concern and it is widely accepted that there is a link between childhood obesity and morbidity and mortality in later life (Adamson et al., 2007; Reilly et al., 2003). Obesity disproportionately affects certain population groups. As in other high income countries, obesity is associated with social and economic deprivation across all age ranges and recent research suggests that this gradient is embedded with little evidence of change over time (Adamson et al., 2007). Further, it is known that minority ethnic groups and individuals with a mental health problem or physical disability are disproportionately affected by obesity (Adamson et al., 2007; Allison et al 1999; Dinan 2004). Geographical inequalities are also evident, with hotspots in the North East, Yorkshire and Humber, and the East and West Midlands (Adamson et al., 2007).

3.3. Alcohol

The relationship between socioeconomic status and alcohol is complex. For example, people with lower socioeconomic status are more likely to abstain, or, if they do consume alcohol, to have problematic drinking patterns and dependence, whereas those with higher socioeconomic status are likely to drink more often but to consume smaller amounts (Rickards, Fox & Roberts, 2004; Van Oers et al, 1999). In England across all regions, hospital admission for alcohol-specific conditions for both males and females is associated with increased levels of deprivation, with rates of admission for the most deprived quintiles being particularly high (Deacon et al, 2007). The number of alcohol-related deaths varies between English regions and also within regions. In 2005 the percentage of alcohol-specific deaths for both males and females were highest in the North West.

3.4. Drug use

The links between drug use and social and economic inequalities are well recognised in literature and research: There is a significant positive correlation between the prevalence of problematic drug users aged 15-64 years and the deprivation indices of a local authority. Similarly, admission rates for drug-specific conditions for both males and females show a strong positive association with deprivation. Additionally, much of UK drug policy seeks to address factors that contribute to inequalities amongst drug users. The latest UK drug strategy, *Drugs: protecting families and communities* (Home Office, 2008) highlights the fact that vulnerable individuals, those who live in deprived communities and are part of disadvantaged families, are disproportionately affected by problem drug use.

3.5. Injuries and violence.

The burden of injuries and violence in the UK is not equally distributed across the population, and some groups appear to be more affected than others. Incidence varies with a number of factors, which are often interlinked. These include: age, gender, socioeconomic status, ethnicity and geographical location. The relationships between these factors and injuries and violence often depend on the cause of injury (e.g. road traffic accident, fall, fire-related accident) or type of violence (e.g. self-directed violence or interpersonal violence). In general, there are higher rates of injuries and violence victimisation among individuals with a lower socioeconomic status, measured either at an area-of-residence or individual level. These associations have been reported for all age groups, and for a variety of injury types.

3.6. Mental Health

In terms of disability-adjusted life-years (DALYs), mental health problems are the biggest source of health-related disability and suffering in high-income

countries, accounting for 26% of the total disease burden and over 40% of 'Years Lost due to Disability'. Unipolar depression alone accounts for 8% of the disease burden - more than any other condition (WHO 2008). In England, 23% adults met the diagnostic criteria for at least one mental health problem in the most recent national psychiatric morbidity survey (McManus et al 2009). Mental health is intimately connected with many forms of inequality. Consistent associations have been found between mental ill health and various markers of social and economic adversity – e.g. low education, low income; low socioeconomic status; unemployment; and poorer material circumstances (Melzer et al 2004). The social gradient is particularly pronounced for severe mental illness. For example, in the case of psychotic disorders the prevalence amongst the lowest quintile of household income is nine times higher than in the highest (McManus et al, 2009). However, the social gradient is also evident for common mental health problems, with a two-fold variation between the highest and lowest quintiles (McManus et al, 2009). Poor mental health also increases the incidence of and worsens the prognosis for a wide range of physical health conditions, including heart disease, stroke, cancer, diabetes and asthma. It is associated with a variety of risk factors such as smoking, drug use, alcohol abuse and obesity. It is therefore also important to consider the role of mental health and well-being when tackling inequalities across all priority public health conditions.

3.7. Health and Wellbeing of Older People

According to Age Concern, approximately one in five older people live in poverty (Age Concern England, 2006). Data from the Health Survey for England 2005 show that disparities exist between low and high socioeconomic groups in a number of health indicators for older people, with people in the lowest quintile of income reporting poorer general health, lower levels of fruit and vegetable consumption and higher degrees of mobility problems and lower-limb impairment (Craig and Mindell, 2007). Similarly, the prevalence of ischaemic heart disease amongst older people is higher in the most deprived areas. Diabetes prevalence and uncontrolled hypertension are also inversely related to income (Craig and Mindell, 2007). Chandola et al (2007) illustrated, using longitudinal data from the Whitehall II study, that people from lower occupational grades showed a steeper decline in physical health than those in higher grades. Differences in self-reported health were also found between occupational grades, and a widening of relative inequality was demonstrated with increasing age. It should be noted that the evidence base regarding issues of inequality in older people's health is less developed when compared with inequalities research in the working-age population (McMunn et al., 2006).

4. Policy context

Past strategies to tackle inequality have largely focused on either improving the health of the most deprived groups or narrowing the gap between the best- and worst-off in society. Universal strategies to address health disadvantage across the social gradient have been fewer. In many instances policy has focused on downstream interventions such as smoking cessation services or GP referrals for physical activity rather than tackling distal causes such as poor living conditions and unemployment. This approach is in contrast to a wide body of epidemiological and sociological work which suggests that health inequalities are likely to persist between socioeconomic groups even if lifestyle factors (such as smoking) are equalised (Health Select Committee, 2009: paragraph 47). Indeed, Phelan et al (2004) suggest that the only way to achieve lasting reductions in inequality is to address society's imbalances with regard to power, income, social support and knowledge.

5. Background to the Proposals

Our proposals for tackling inequalities in priority public health conditions are necessarily wide-ranging, reflecting the fact that the “causes of health inequalities are complex, and include lifestyle factors – smoking, nutrition, exercise to name only a few – and also wider determinants such as poverty, housing and education” (Health Select Committee, 2009). We acknowledge that the most effective strategy to improve health across the population, and to reduce health inequalities, is to implement upstream policy interventions that reach across sectors and create an environment (economic, social, cultural and physical) that fosters healthy living. However, these need to be supported by downstream socially-targeted interventions to mitigate any adverse distributional consequences. We have therefore proposed a mix of both upstream and downstream solutions.

There are four unifying themes within our set of interventions:

- a) The importance of improving the physical, social and economic environment of deprived areas (e.g. improving access to high nutrient foods, providing safe places for physical activity, improving the quality of housing, or increasing the level of employment).
- b) The long-term public health benefits of intervening early in the life-course to prevent the development of risky health behaviours or chronic conditions (e.g. childhood socialisation schemes to reduce violence; improved infant and maternal health and nutrition).
- c) The importance of considering the close interplay between physical and mental health when designing strategies to reduce health inequalities
- d) The use of fiscal and financial policy instruments to enable deprived populations to live healthier lives (e.g. cigarette pricing, minimum

price for alcohol, financial incentives to reduce drug dependence, or a minimum income for healthy living).

Our proposals therefore naturally overlap with the remit of some of the other Marmot review task groups, particularly Task Group 1 (early child development and education), Task Group 2 (employment and work), Task Group 3 (social protection), Task Group 4 (built environment), Task Group 5 (sustainable development), and Task Group 9 (social inclusion and mobility). Such overlaps are detailed below.

An important consideration in terms of our review of the evidence on effective interventions to tackle inequalities in the priority public health conditions is the fact that there is far more evaluation evidence of downstream interventions than there is of upstream interventions. This is despite the well-acknowledged importance of upstream interventions in reducing health inequalities (e.g. Phelan et al, 2004). This may reflect the fact that, in the past, downstream (e.g. lifestyle) interventions have been easier to identify and to evaluate. Our research proposal therefore contains the suggestion that in the future, more evaluations of upstream interventions need to be conducted and funded.

Additionally, our research proposal also suggests that all future evaluations of public health interventions should incorporate a health inequalities dimension. This is because in all of the priority health conditions covered by Task Group 8 there was a dearth of evidence on the effectiveness of interventions in tackling health inequalities between groups, as opposed to a general improvement in population health. For example, in chapter 2 of this report, Lobstein comments that “systematic reviews of evidence for the prevention of obesity show remarkable paucity in identifying successful means of reducing inequalities”. This problem has been noted elsewhere (Bambra et al, 2008). Our policy proposals are therefore based on extrapolation from this general population health evidence as it is all that is available. Implicitly, we have been guided by the assumption that as the burden of public health priority conditions disproportionately falls upon lower socioeconomic groups, interventions which have been shown to be generally effective in preventing or treating these conditions could, if targeted at deprived groups or areas, be effective in reducing health inequalities.

Proposals

Here we list our 15 proposals alongside a synopsis of the supporting evidence. We have subdivided our 15 proposals into five key proposals, one research proposal and nine supporting proposals. Proposals in the latter category are those which overlap with the proposals of the other Marmot review task groups (cross-referenced where appropriate). Further information on each of the proposals is contained in the relevant sections of the main Report of the Task Group. Details of the references given can also be found in the main Report.

1) Five Key Proposals

Proposal 1: Reduce smoking in the most marginalised groups by focusing on price and availability, while providing stop smoking services targeted to help the poorest groups quit.

- Prioritise deprived and marginalised groups, including routine and manual socioeconomic groups, and people with mental health problems in the design and targeting of all stop smoking services, campaigns and interventions
- Reintroduce an annual above-inflation price escalator for tobacco products
- Abolish prescription charges for nicotine replacement therapy for all smokers who want to quit, which has been done in Scotland and Wales (5 year target)
- Set tough new targets for the control of tobacco smuggling (5 year target)
- Reduce the illicit market share for cigarettes to no more than 8% by 2010 and 3% by 2015. Reduce the illicit market share for hand-rolled tobacco to no more than 45% by 2010 and 33% by 2015.

Supporting Evidence: Smoking accounts for around half the difference in life expectancy between the lowest and highest income groups, and smoking-related death rates are two to three times higher among disadvantaged social groups than among the better off (Scarborough et al., 2008; Jarvis and Wardle, 2006). Tobacco control is therefore central to any strategy to tackle health inequalities and to any prevention strategy. Increasing the price of smoking is the most effective means of helping smokers quit. However, tobacco tax is strongly regressive and for those smokers who do not quit it can increase health inequalities, particularly for less affluent smokers. On the other hand, real price increases do help lead some smokers to quit and make very substantial health and welfare gains for those that do quit. This poses a

dilemma, which can be resolved only by making the greatest possible efforts to motivate and assist smokers to quit in response to increases in taxation. This would include greater emphasis in smoking cessation initiatives on the psychosocial reasons for smoking. Preventing people from starting to smoke or helping them quit requires measures at population level that impact on all the key levers: price, promotion, place and product, also known as the marketing mix (Action on Smoking and Health, 2008).

Proposal 2: Improve availability of and access to healthier food choices amongst low income groups

- National and local government should positively influence public opinion and cultural norms around healthy diets (social marketing campaigns; well-resourced advocacy groups, public health groups; link to policies for food security, environment, animal welfare, fair trade).
- The Treasury should undertake a review to reformulate how it calculates minimum income standards and benefit levels, in order to ensure that families can afford the essential requisites to give their children a healthy start in life.
- The government should explore fiscal policies (VAT adjustments e.g. Denmark; product and distribution subsidies to small and medium sized food retailers; remove tax-exemption for marketing specified foods; include explicit 'food basket' component when setting benefit levels)
- Incentives to distributors (e.g. Norway) and retailers (e.g. Scotland) to promote healthier food choices
- Use of public procurement to aid production and distribution (Cornwall NHS)
- Product reformulation (e.g. salt and sat fat reduction, FSA)
- Easy-to-comprehend and consistent food information (traffic-light front-of-pack labelling – FSA; controls on product health claims – EC)
- Restricted marketing (TV ban on junk food ads pre-9pm; planning controls on fast food outlets e.g. Newham, Knowsley)
- Pre-school, school and workplace food policies (e.g. Nutrition standards for catering and food sales; restricted marketing and advertising, debranding of business links in schools; enhanced health education).

Supporting evidence: The Health Survey for England 2007 demonstrates a clear gradient in the consumption of five or more portions of fruit and

vegetables per day with quintile of household income, the lowest consumption being in the lowest income group. Low income groups are more likely to consume fat spreads, non-diet soft drinks, meat and meat dishes, pizza, processed meats, whole milk and table sugar (Food Standards Agency, 2007). A survey by the National Consumer Council found that the formulation of various types of food tended to be less 'healthy' for the economy lines, cheaper foods for example having higher salt or fat content (National Consumer Council, 2006).

Proposal 3: Improve the early detection and treatment of cancer, diabetes and cardiovascular disease, especially among the more susceptible groups.

- Use social marketing to increase awareness of early symptoms and the importance of early detection/screening for these conditions among the more susceptible groups
- Further incentivise primary care practitioners to focus prevention and early detection of these conditions on the more susceptible groups.

Supporting evidence: Socioeconomic deprivation is a strong predictor of screening participation with expression of interest in colorectal screening and attendance at the test being lower in deprived groups (McCaffery et al., 2002). Similar findings are reported for breast and cervical screening (Baker and Middleton, 2003). Evidence suggests that people from lower socio-economic groups have their cancer diagnosed at a later stage which subsequently affects treatment options and prognosis (Adams, White and Forman 2004). With regard to vascular checks, a recent systematic review (Soljak, Lonergan and Hayward 2009) has found strong socioeconomic and ethnic gradients in uptake of invitations for CV screening.

Proposal 4: Introduce a minimum price per unit for alcohol.

Supporting evidence: A systematic review of 112 studies examining the relationship between prices of alcohol and alcohol sales/self-reported drinking concluded there was a large body of evidence indicating an inverse relationship between alcohol prices and taxes, and drinking. Furthermore in comparison to other prevention policies and programmes, policies which raised prices of alcohol were an effective method of reducing consumption (Wagenaar et al, 2008). Given the social patterning of alcohol consumption, this intervention may disproportionately benefit lower socio-economic groups (Brennan et al, 2008).

Proposal 5: Improve physical healthcare for people with mental health problems and mental healthcare for people with physical health problems.

- Expand the provision of health checks and targeted health promotion services for people with mental health problems, and redesigning the interface between primary care and specialist mental health services.
- Give increased emphasis on the mental/psychosocial dimension of physical health when designing interventions to improve health and reduce health inequalities.
- Encourage the use of primary care registers for people with severe mental illness, in line with NICE guidance
- Improve the identification and treatment of psychological factors underlying 'medically unexplained' physical symptoms.

Supporting evidence: Mental and physical well being are closely interrelated, with higher rates of coronary heart disease, stroke, cancer, diabetes, infections, injuries and asthma amongst people with poor mental health (Prince et al 2007; Blaug et al 2007; Osborn et al 2007). People with a diagnosis of mental illness receive poor quality treatment for physical health problems and are rarely targeted for health promotion initiatives e.g. smoking cessation, healthy eating or exercise (Samele et al 2006). Conversely, people with other priority public health conditions such as diabetes and cancer are more likely to develop mental health problems, and those that do have poorer prognosis in terms of their physical health condition (Chapman et al 2005; Evans et al 2005; McVeigh et al 2006). The interface between primary and secondary care is particularly important in terms of improving healthcare for people with co-morbidities (Samele et al 2006). The NICE Guidance on management of schizophrenia (NICE 2002) supported the development of primary care registers of people with severe mental illness.

2) Research Proposal

Proposal 6: Fund more studies which examine the impacts of interventions on socio-economic health inequalities.

- Government should commission evaluations to establish the effectiveness of interventions in terms of reducing health inequalities. For example, invest in natural experiments to help determine the most effective population-level interventions, with at least 10% of budgets for all initiatives earmarked for evaluation. For complex interventions, use the approach

recommended in the Medical Research Council guidelines (2008).

- There should also be investment in the evaluation of upstream policy interventions.
- Consideration of health equity issues should be integrated into all future Department of Health funded public health evaluations along the lines of the Cochrane Collaboration health equity checklist (Cochrane Collaboration, 2009).

Supporting evidence: In all sections of this report, the authors highlight the fact that whilst there is often evidence of the general health effects of interventions, there is a dearth of evidence in respect to the impacts and cost-effectiveness of interventions on health inequalities. As a recent Public Health Research Consortium report shows (Bambra et al, 2008), this is the case in terms of both primary studies and systematic reviews. Similarly, more research has been conducted on the effects on health inequalities of downstream interventions, as opposed to upstream interventions. The recent Health Select Committee report on health inequalities (2009) also made it clear that the lack of evidence and evaluation of current policies makes it difficult to know how to properly address health inequalities.

3) Supporting proposals

Proposal 7: Improve the social and physical environment to make it easier for lower socioeconomic groups, and the population as a whole, to engage in physical activity

This proposal links with the work of Task Group 4 (Built Environment) and 5 (Sustainable Development):

- Change planning norms (transport and urban design policies to ensure active travel, restrict car use, building controls to raise incentives for stair use, Health Impact Assessments to match Environmental Impact Assessments).
- Walking and cycling must be at the centre of transport policy at national and local levels. The Department for Transport should commit at least 10% of its budgets to walking and cycling.
- Require training in assessing public health impacts for urban and transport planners, architects and engineers.
- Continue to make PCTs statutory consultees in planning decisions. The NHS London Healthy Urban Development Unit has done significant work helping PCTs engage in the planning process and is a good resource for moving forward.

- Improve the quality, affordability and safety of public transport to ensure that it is a viable transport option, especially taking into account the needs of the disabled, elderly, and morbidly immobile.
- Increased availability of open spaces (Incentives to protect and develop open spaces/green spaces; enhanced safety features e.g. reduced traffic; enhanced security e.g. lighting, CCTV; protection of open sports fields, promotion of clubs; more cycle routes and cycle priority networks)
- Fiscal policies (business tax incentives for workplace activity facilities; disincentives for car use, removal of tax-deductible car costs; business rate charges for car-parking; VAT adjustments on sports and activity equipment; additional car and fuel purchase taxation, congestion charging, parking fees, road tax)
- Pre-school, school and workplace activity policies (Timetabled opportunities for activity; code of practice for sedentary hours per day; enhanced health education; support for out-of-hours use of school sports facilities by community)
- Change public opinion and cultural norms around physical activity (via social marketing campaigns; well-resourced advocacy groups, public health groups, make links to policies for environment, global warming, carbon tax etc).

Supporting evidence: Regular physical activity can reduce the risk of CHD, obesity, depression and many other avoidable chronic diseases (WCRF, 2009). Environmental factors are important in terms of promoting (or preventing) physical activity. Studies have found that the lowest socioeconomic group is most likely to be inactive regarding recreational walking (Kamphuis, et al., 2009). Those in lower socio-economic groups are more likely to suffer from a poorer built environment with higher rates of traffic accidents, higher rates of crime which discourages people from walking and cycling in their neighbourhoods, and less access to green space and other leisure facilities. For example, the Department of Transport estimated that in 2007 there were 2500 “excess” pedestrian casualties in deprived areas (House of Commons Health Committee, 2009).

Proposal 8: Improve infant and maternal nutritional status

This proposal links with the work of Task Group 1 (Early Child Development and Education):

- Targeted measures to improve teenage girls’ diet and increase their physical activity

- Enhance standards for availability and accessibility of pre-conception and antenatal care and advice
- Review fortification offers for women on benefits under pre-conception or antenatal care
- Review 'food basket' component of benefits for women under pre-conception or antenatal care
- Improve advice and support on healthy weight maintenance during pre-conception and pregnancy
- Fully implement WHO-UNICEF Marketing Code for Breast-milk Substitutes
- Enhance social marketing for breastfeeding
- Provide breast-feeding facilities in public, workplace etc settings
- Provide Nordic levels of maternity leave
- Review benefit levels for food component for younger children

Supporting evidence: Women in lower socioeconomic groups are also more likely to have under- and over-weight babies (both of which are risk factors for later obesity) and are less likely to follow recommended breastfeeding and weaning practices (an additional risk factor for later obesity). Two systematic reviews found that breastfeeding support programmes can be effective for women in low income groups but that education alone had no effect (Robertson et al, 2007).

Proposal 9: Enhance the psycho-social wellbeing of lower socioeconomic groups.

This proposal links with the work of Task Group 9 (Social Inclusion and Social Mobility):

- Enhance and extend evidence-based community engagement programmes targeted at deprived areas and communities
- Focus on youth schemes to enhance societal participation and contribution, from around age 10
- Home visiting and Health Buddies schemes to promote health and reduce isolation
- Review the formulae for calculating the minimum wage and welfare benefits and link more closely to average earnings to reduce income differentials.

Supporting evidence: Morris et al (2001) illustrated how gains in health and reduction in inequalities could be achieved through improved provision of basic and unmet needs relating to nutrition, physical activity, housing, psychosocial interactions, transport, and healthcare. Based on international

comparisons of countries with developed economies, obesity prevalence is significantly correlated with higher levels on income inequality (Pickett et al, 2005).

Proposal 10: Extend use of contingency management within drug treatment programs.

This proposal links with the work of Task Group 7 (Delivery Systems and Mechanisms):

Supporting evidence: NICE states that contingency management (giving incentives such as vouchers or cash to drug users to quit or reduce consumption) is the 'only psychosocial intervention with clear evidence for effectiveness as an adjunct to detoxification' (NICE, 2007a). There is strong evidence for its use (Higgins et al, 2004; Lussier et al, 2006; Prendergast et al, 2006; Roll, 2007; Stitzer and Vandrey, 2008). For instance, an evaluation of a US program which offered vouchers as incentives to cocaine users to abstain found significantly greater treatment retention and cocaine abstinence than usual care, with 68% of behavioural treatment patients achieving 8 weeks of continued abstinence during treatment compared with 11% of patients receiving standard care (Higgins et al, 1993).

Proposal 11: Widely extend 20mph maximum speed zones especially in residential and inner city/town areas.

This proposal links with the work of Task Group 4 (Built Environment):

Supporting evidence: In general, increased deprivation is associated with higher rates of injury or death from a road traffic accident (e.g. Adams et al, 2005; Edwards et al, 2006; Graham et al, 2005). There is good evidence that 20mph zones are effective in reducing traffic speeds and reducing injuries in the general population, and in children in particular (Morrison et al, 2003; Towner et al, 2001). For example, a review of 20mph zones in London in 2003 found that the frequency of injury accidents in the zones had reduced by around 42%, and serious or fatal injuries by around 53% since their implementation (Webster and Layfield, 2006).

Proposal 12: Widely extend early-years interventions, in particular pre-school enrichment programmes and school based social development programmes.

This proposal links with the work of Task Group 1 (Early Child Development and Education):

Supporting evidence: There is strong evidence from US-based studies that high quality pre-school enrichment programmes (early academic and social skills such as literacy and numeracy, socialisation, problem-solving and the development of self-esteem) targeted in deprived areas can have long-term positive impacts on participants, including reduced involvement in violence, better mental health and improved educational and work achievement (WHO, in press). Internationally, the evidence base for the effectiveness of school-based social development programmes (skills taught include anger management, behaviour modification, moral development, empathy, developing and maintaining healthy relationships, problem solving and conflict resolution) is robust with well-implemented programmes having been found to improve social skills and reduce aggression in young people (WHO, in press).

Proposal 13: Improve prevention and treatment of childhood mental health problems across the whole social gradient, with a particular focus on disadvantaged groups.

This proposal links with the work of Task Group 1 (Early Child Development and Education):

- Increase provision of targeted prevention programmes e.g. parent-training/education programmes; school-based social skills training.
- Improve detection of childhood mental health problems in schools and primary care
- Increase access to effective treatments, for example through expansion of the child psychologist workforce, and ensuring that NICE guidelines are adhered to

Supporting evidence: Childhood mental health problems are strongly socially patterned, being several times more common amongst low income groups, and amongst other marginalized groups such as children in care and young offenders (Green et al 2005; Meltzer et al 2003; Lader et al 2000). They also have profound consequences for a variety of outcomes in adult life (Ferguson et al 2005; Stewart-Brown 2004; Scott et al 2001). NICE guidelines (e.g. NICE 2005, 2007b, 2008a) outline a number of effective treatment interventions. However, only a quarter of those with a clinically diagnosable disorder have seen any mental health professional in the last year (Meltzer et al, 2003a, 2003b). Given the social patterning of mental ill health in childhood, simply increasing the availability of evidence-based treatments should have an impact on health inequalities (Layard & Dunn, 2009). There is also strong evidence that mental health problems can be prevented through the use of

targeted interventions (US DHHS, 2007). The cost-effectiveness of these interventions is high, with many more than paying for themselves in terms of reduced costs to society as a result of avoided health and social problems later in life (Fonagy et al, 2002; Waddell et al 2007).

Proposal 14: Decrease the association between mental ill-health and unemployment through the use of both targeted support and broader health promotion approaches.

This proposal links with the work of Task Group 2 (Employment Arrangements and Working Conditions):

- Use effective, evidence-based methods (e.g. Individual Placement and Support) to support people with severe mental illnesses to get and keep paid work
- Encourage the creation of healthier workplaces by spreading existing good practice, with the public sector taking a lead

Supporting evidence: Research indicates a strong, bidirectional relationship between mental ill health and unemployment (Singleton et al, 2001; Waddell & Burton 2006). The most recent data indicates that 42% of people in the UK claiming Incapacity Benefits do so because of mental ill health (DWP 2008). The most effective approach for supporting people with severe mental health problems into employment is provided by the Individual Placement and Support (IPS) model (Bond et al. 2008). Workplaces can also implement cost-effective health promotion approaches - responding better to mental distress among their staff and thereby preventing the downward spiral of mental ill health, job loss and long-term poverty and exclusion that plays such a key role in generating and maintaining health inequalities (Sainsbury Centre, 2007).

Proposal 15: Implement a Minimum Income for Healthy Living (MIHL) in Older People

This proposal links with the work of Task Groups 3 (Social Protection) and 9 (Social Inclusion and Social Mobility):

- Implement a minimum income for healthy living (MIHL) in older people is a preventive approach which would work upstream on the broader determinants of health by ensuring equality of opportunity to satisfy basic requirements for personal health.

Supporting evidence: Based on the inextricable link between income and health, Morris et al (2001) illustrate how gains in health and reduction in inequalities can be achieved through provision of basic and unmet needs relating to nutrition, physical activity, housing, psychosocial interactions, transport, medical care and hygiene. Recent analyses show that there is a deficit between the current state pension (supplemented with pension credit guarantee and winter fuel allowance) and the calculated MIHL (Morris et al., 2007). The MIHL model would provide a template for conceptualising the relationship between income and health needs, thus helping to facilitate a shift in thinking towards upstream strategies to tackle pervasive patterns of inequity. Both Age Concern England and the World Health Organisation support such a proposal.

References

Details of all the references quoted in this summary document are provided in the main Report of the Task Group.